RIVERSIDE TOWNSHIP
Mental Health Board
Consultant's Report
(February 19, 2025)

1. Dr. Troiani attended the Monday - February 10th Illinois Mental Health Summit meeting and on that same day the Policy Committee meeting of Mental Health America of Illinois.

2. All eyes are on Washington D.C. with the incoming Secertary of the Department of Health and Human Services (DHHS) and DOGE audit of the department's performance.

3. Governor Pritzker's annual Budget and State of the State Address will be held on February 19, 2025, at 12:00 P.M. DHS and HFS along with other Health and Human Service Departments will hold a budget briefing after the Governors Address at 2 P.M. Deputy Governor Grace Hou and First Assistant Deputy Governor Ryan Croke, along with the leaders of the Departments of Human Services (IDHS), Healthcare and Family Services (HFS), Public Health (IDPH), Aging (IDoA), Children and Family Services (DCFS), and Veterans Affairs (IDVA) will provide a brief overview of the FY26 proposed budget - immediately followed by a Q&A session. The following is the SFY 2026 Health and Human Services Budget Briefing Link:

   https://multimedia.illinois.gov/FY26-HHS-Budget-Briefing-live.html

4. Trade association lobbyists are cautioning trade associations and advocacy groups that no additional money should be requested. The real challenge in the SFY 2026 budget will be to maintain state funding at SFY2025 levels. The most likely scenario will be budget reductions.

5. The State of Illinois fiscal crisis is impacted by the following factors:

   - State pension underfunding has worsened with Illinois now ranked 50th out of 50 states. Prior position was 47th.
   - COVID-19 funding from the federal government has come to an end. Due to fraud, waste and abuse there might be an effort by the federal government to recoup some of this money by auditing grant recipients which could put them in a payback position.
   - The coming cuts to the federal Department of Health and Human Services (DHHS) will translate into even less federal money coming to the States.
   - The cost of providing services to undocumented immigrants and asylum seekers in the State of Illinois from July 1, 2022, to April 1, 2024, was $2.84 billion dollars. The state 2025 fiscal year budget is $629 million dollars. We will be learning at the budget address the SFY 2026 will be

calculated. Illinois is only one of five states that provide Medicaid benefits to this population. It is anticipated that there will not be any financial relief from the current administration in Washington D.C.

- The Governor of Illinois has pledged at this time that there will be no new taxes or tax increases.

6. There has been an important development regarding the future of behavioral health services in Illinois. According to the Chicago Tribune, Governor Pritzker issued an Executive Order (attachment "A") establishing the Division of Behavioral Health and Recovery, which will take effect on July 1, 2025, which is the start of State Fiscal Year 2026. This restructuring marks a significant change, and there are many questions about its impact on the mental health and substance use field.

   Currently, details about the full scope of this transition are still emerging. Recognize that change can bring uncertainty, but the professional and trade associations are committed to engaging in ongoing dialogue with state leadership, advocating for the field, and keeping their members informed. They are working closely with their lobbyists and other key stakeholders to gain clarity on how this transition will affect credentialing, workforce development, and service delivery
   As more information becomes available, I will provide continued updates and opportunities for discussion. Currently, it is important to have focus and collaboration among the stakeholders as this transition unfolds.

7. Dial #988 updates:

   Due to the overall poor performance in the implementation of the nationwide dial #988 system, continued funding might be in jeopardy. My analysis of the Dial #988 system is that when the Department of Government Efficiency (DOGE) reviews the delayed implementation, poor performance, and cost of this program, it might be eliminated. I have enclosed (attachment "B") several articles including a study on the Dial #988 system and a report on one state's experience.

   - RAND Report: Most Mental Health Crisis Services Did Not Increase Following the Launch of 988 Crisis Hotline (January 29, 2025).
   - JAMA Psychiatry Published online on January 29, 2025, Changes in Specialty Crisis Services Offered before and after the launch of the 988 Suicide and Crisis Lifeline.
   - From STAT News (statnews.com - Reporting from the frontiers of health and medicine) is a health report titled, Since 988 launch, mental health services have faltered: Study shows the nationwide system is falling well short of its potential, while funding issues loom.
   - Commentary Article dated January 30, 2025, Montana's Mental Health Crisis: How One County's Mobile Crisis Response Team is Filling Gaps and Saving Lives.

8. As reported by the Illinois Association for Behavioral Health (IABH), they are actively working to address the funding gap in Substance Use Prevention and Recovery (SUPR) contracts resulting from last year's contract right-sizing. IABH is developing a proposal to utilize opioid settlement funds to cover services not included in existing contracts or Medicaid, aiming to avoid supplanting current funding.

   Following a formal letter to Governor Pritzker regarding the SUPR contract shortfall, SUPR agreed to reassess contracts. However, the redistribution of funds from underutilized provider contracts may not fully compensate for last year's reductions. SUPR reports that substance use disorder providers are now using their contracts at a higher rate than the amount reduced during right-sizing.

   Illinois is set to receive over $1.3 billion in opioid settlement funds by 2038, earmarked for statewide opioid crisis abatement. IABH's proposal seeks to leverage these funds to support critical recovery and treatment programs throughout Illinois, addressing the ongoing needs of providers and communities affected by the opioid epidemic.

   The Mayor of the City of Chicago has diverted the entire opioid settlement award to cover the cost of providing services to undocumented immigrants and asylum seekers.

9. Attachment "C" is information regarding the Illinois loan repayment program. One strategy to address the workforce shortage is the expansion of the student loan forgiveness programs. I am currently involved with several advocacy organizations (i.e. Illinois Mental Health Summit, Illinois Certification Board, and Mental Health America of Illinois) which have been instrumental in advocating and supporting legislation/budget allocation for these programs as a way of addressing the workforce shortage here in Illinois. I will continue to pass on information on these programs as comes across my desk. The link for more information is as follows:
   https://www.isac.org/students/after-college/forgiveness-programs/community-behavioral-health-care-professional-loan-repayment-program.html

10. Attachment "D" is an article dated December 1, 2024, titled, Why Does America's Falling Epidemic Keep Getting Worse? By Peter Funt.

Respectfully Submitted,

Joseph E. Troiani

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STATE OF ILLINOIS

EXECUTIVE DEPARTMENT

SPRINGFIELD, ILLINOIS

February 14, 2025 Executive Order 2025-01

EXECUTIVE ORDER 2025-01
EXECUTIVE ORDER TO REORGANIZE THE DEPARTMENT OF HUMAN SERVICES AND CONSOLIDATE THE DIVISIONS OF MENTAL HEALTH AND SUBSTANCE USE PREVENTION AND RECOVERY, CREATING THE NEW DIVISION OF BEHAVIORAL HEALTH AND RECOVERY

WHEREAS, Article V, Section 11 of the Illinois Constitution authorizes the Governor to reassign functions or reorganize executive agencies that are directly responsible to him by means of executive order;

WHEREAS, Section 3.2 of the Executive Reorganization Implementation Act, 15 ILCS 15/3.2, provides that "Reorganization" includes 'the consolidation or coordination of any part of any agency or the functions thereof with any other part of the same agency or the functions thereof;'

WHEREAS, the Department of Human Services' (Department) Division of Mental Health (DMH) and the Department's Division of Substance Use Prevention and Recovery (SUPR) are divisions within an executive agency directly responsible to the Governor and exercise the rights, powers, duties, and responsibilities derived from 20 ILCS 1305 *et seq.*;

WHEREAS, there is a substantial overlap in persons served by DMH and SUPR, as one in four individuals with a serious mental illness also has a substance use disorder, almost 50% of inpatient substance use disorder patients have a co-occurring psychiatric disorder, and approximately 32% of inpatient psychiatric patients have a co-occurring substance use disorder;

WHEREAS, many Illinois service providers serve consumers of both DMH and SUPR, with 61 community mental health centers also licensed to provide substance use disorder services, and 17 having grants with both current Divisions;

WHEREAS, recovery from substance use disorders and mental illnesses, defined as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential, is a primary goal for behavioral health care and will benefit from the broader availability of integrated substance use and mental health services;

WHEREAS, the consolidation of DMH and SUPR will leverage the expertise of staff from both Divisions, improve accessibility and accountability, improve outcomes for Illinoisans who have both mental illnesses and substance use disorders, reduce administrative burden on providers, and enhance substance use disorder treatment in State-Operated Psychiatric Hospitals, among other improvements;

WHEREAS, for the foregoing reasons, it is appropriate and most beneficial to consolidate DMH and SUPR into a new integrated division;

WHEREAS, pursuant to the consolidation of DMH and SUPR, the initiatives and programs of both agencies will be preserved and maintained; and

Printed by the Authority of the State of Illinois

WHEREAS, the consolidation of DMH and SUPR will improve access to care for consumers and patients, streamline processes, strengthen the workforce, and allow staff to be more responsive to the needs of Illinois residents.

NOW, THEREFORE, I, JB Pritzker, Governor of the State of Illinois, pursuant to the executive authority vested in me by Article V, Section 11 of the Illinois Constitution, hereby order the following:

I. CONSOLIDATION OF FUNCTIONS

Effective on July 1, 2025, or as soon thereafter as practicable, powers, duties, rights, and responsibilities related to DMH and SUPR shall be consolidated into a single entity called the Division of Behavioral Health and Recovery within the Department of Human Services. The statutory powers, duties, rights, and responsibilities of DMH and SUPR derive from the following and all other relevant statutes, as well as the regulations promulgated thereunder, including, but not limited to:

a. Substance Use Disorder Act, 20 ILCS 301 *et seq.*;
b. Civil Administrative Code of Illinois (Department of Human Services (Alcoholism and Substance Abuse) Law) 20 ILCS 310 *et seq.*;
c. Department of Human Services Act, 20 ILCS 1305 *et seq.*;
d. Mental Health and Developmental Disabilities Administrative Act, 20 ILCS 1705 *et seq.*;
e. Civil Administrative Code of Illinois (Department of Human Services (Mental Health and Developmental Disabilities) Law) 20 ILCS 1710 *et seq.*;
f. Illinois Public Aid Code, 305 ILCS 5 *et seq.*;
g. Mental Health and Developmental Disabilities Code, 405 ILCS 5 *et seq.*;
h. Illinois Vehicle Code, 625 ILCS 5 *et seq.*;
i. Sexually Violent Persons Commitment Act, 725 ILCS 207 *et seq.*;
j. Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110 *et seq.*;
k. Unified Code of Corrections, 730 ILCS 5 *et seq.*;
l. Code of Criminal Procedure of 1963, 725 ILCS 5 *et seq.*; and
m. Illinois Controlled Substances Act, 720 ILCS 570 *et seq.*

II. EFFECT OF CONSOLIDATION

a. The powers, duties, rights, and responsibilities vested in DMH and SUPR shall be consolidated and vested in the new Division of Behavioral Health and Recovery. Each act done in the exercise of such powers, duties, rights, and responsibilities by the Division of Behavioral Health and Recovery shall have the same legal effect as if done by DMH or SUPR.

b. The employees of DMH and SUPR shall be transferred and consolidated into the new Division of Behavioral Health and Recovery. The status and rights of DMH and SUPR employees under the Personnel Code shall not be affected by the consolidation.

c. All books, records, papers, documents, property (real and personal), contracts, and pending business pertaining to the powers, duties, rights, and responsibilities related to DMH and SUPR and consolidated by this Executive Order, including but not limited to material in electronic or magnetic format and necessary computer hardware and software, shall be delivered to the new Division of Behavioral Health and Recovery.

d. Any rules, regulations, obligations, and other actions of DMH or SUPR shall be transferred and continue as rules, regulations, obligations, and actions of the Division of Behavioral Health and Recovery. The Department of Human Services shall modify any rules, regulations, obligations, or other actions, as necessary, to carry out the reorganization.

e. No obligations arising from any civil or criminal penalties previously imposed are affected by this Executive Order. Every person or entity shall be subject to the same obligations and duties and any penalties, civil or criminal, arising therefrom, and shall have the same rights arising from the exercise of such powers, duties, rights, and responsibilities as had been exercised by DMH or SUPR or its officers or employees.

f. Whenever reports or notices are now required to be made or given or papers or documents furnished or served by any person to or upon DMH or SUPR in connection with any of their functions consolidated by this Executive Order, the same shall be made, given, furnished, or served in the same manner to or upon the new Division of Behavioral Health and Recovery.

g. This Executive Order shall not affect any act done, ratified, or canceled or any right occurring or established or any action or proceeding had or commenced in an administrative, civil, or criminal cause regarding DMH or SUPR before this Executive Order takes effect; such actions or proceedings may be defended, prosecuted, and continued by the Division of Behavioral Health and Recovery.

III. SAVINGS CLAUSE

This Executive Order does not contravene, and shall not be construed to contravene any contracts, agreements, or collective bargaining agreements.

IV. PRIOR EXECUTIVE ORDERS

This Executive Order supersedes any contrary provision of any other prior Executive Order.

V. SEVERABILITY

If any provision of this Executive Order or its application to any person or circumstance is held invalid by any court of competent jurisdiction, this invalidity does not affect any other provision or application of this Executive Order which can be given effect without the invalid provision or application. To achieve this purpose, the provisions of this Executive Order are declared to be severable.

VI. FILING AND DELIVERY

This Executive Order shall be filed with the Secretary of State. A copy of this Executive Order shall be delivered to the Secretary of the Senate and to the Clerk of the House of Representatives and, for the purpose of preparing revisory legislation, to the Legislative Reference Bureau.

VII. EFFECTIVE DATE

Provided that neither house of the General Assembly disapproves of this Executive Order by the record vote of a majority of the members elected, this Executive Order shall take effect 60 days after its delivery to the General Assembly.

JB Pritzker Governor

Issued by the Governor: February 14, 2025
Filed with the Secretary of State: February 14, 2025

Most Mental Health Crisis Services Did Not Increase Following Launch of 988 Crisis Hotline

FOR RELEASE
Wednesday
January 29, 2025

The launch of the nation's 988 mental health hotline did not coincide with significant and equitable growth in the availability of most crisis services, except for a small increase in peer support services, according to a new RAND study.

Examining reports from thousands of mental health treatment facilities about the types of crisis services offered before and after the July 2022 rollout of the 988 hotline, researchers found that there was an increase in peer support services, a significant decrease in psychiatric walk-in services, and small declines in mobile crisis response and suicide prevention services.

Significant variation across states was observed in service availability trends before and after 988. The findings are published in the journal *JAMA Psychiatry*.

"The lack of meaningful growth in most crisis services may limit the long-run success of 988, in particular if callers feel that reaching out to 988 fails to result in access to appropriate sources of care," said Jonathan Cantor, lead author of the study and a policy researcher at RAND, a nonprofit research organization.

"Mental health officials and policymakers should consider strategies to boost the financing and availability of crisis services at mental health treatment facilities to meet increased demand generated by the 988 Suicide and Crisis Lifeline," Cantor said.

The 988 Suicide and Crisis Lifeline provides an easy-to-remember phone number to access trained crisis counselors and emergency mental health services. It replaced the National Suicide Prevention Lifeline, which had been reachable via an 800 phone number and was narrowly focused on suicide as opposed to mental health crises more broadly.

The 988 crisis line is intended to complement other forms of mental health emergency response services and connect callers with a variety of mental health services on the crisis care continuum.

However, mental health emergency response systems may not be amenable to rapid change despite increases in demand prompted by 988. In particular, the United States continues to contend with a shortage of psychiatric beds in many regions, as well as a limited and unevenly distributed mental health care workforce.

RAND researchers evaluated the availability of crisis services offered by mental health treatment facilities throughout the United States from November 2021 through June 2023.

Information came from details reported by licensed mental health treatment facilities to the Substance Abuse and Mental Health Services Administration. RAND has aggregated that data over time to create the longitudinal Mental Health and Addiction Treatment Tracking Repository. The study included information from a large sample of reports from more than 15,000 mental health treatment facilities nationally.

The largest changes were observed for peer support services, which increased from being available at 39 percent of facilities prior to 988 to 42 percent afterward, and for availability of emergency psychiatric walk-in services, which declined from 32 percent to 29 percent.

The availability of other service types at mental health treatment facilities also declined at the national level. Mobile crisis response dropped from being provided by 22 percent of facilities before the rollout of 988 to being offered by 21 percent afterward. The availability of suicide prevention services dropped from 69 percent to 68 percent over the period.

There were also significant differences observed in crisis service availability based on facility characteristics. For example, public facilities had the highest odds of offering each of the four crisis services, followed by not-for-profit facilities. For-profit facilities, which comprised about one-quarter of the sample, consistently had the most limited services.

State-level rates of suicide prevention services remained the same for most states over the study period. The largest increase in the availability of suicide prevention services was seen in Montana (11.5 percent increase), and the largest decline in availability was in Rhode Island (11.4 percent decrease).

In contrast, most states experienced an increase in the number of facilities offering peer support services. The largest gain in offering of peer support services was in Kansas (19.6 percent increase) and the largest decline in peer support services was found in Georgia (3.2 percent decrease).

Support for the study came from the National Institute of Mental Health. Other authors of the study are Megan S. Schuler, Rose Kerber, and Ryan K. McBain, all of RAND, and Jonathan Purtle of New York University.

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Original Investigation

January 29, 2025

Changes in Specialty Crisis Services Offered Before and After the Launch of the 988 Suicide and Crisis Lifeline

Jonathan Cantor, PhD[1]; Megan S. Schuler, PhD[2]; Rose Kerber, MPP[3]; et al

» Author Affiliations

JAMA Psychiatry. Published online January 29, 2025. doi:10.1001/jamapsychiatry.2024.4548

Key Points

Question Did the launch of the 988 Suicide and Crisis Lifeline in July 2022 influence the availability of crisis services offered by mental health treatment facilities in the US?

Findings This cohort study of 15 623 mental health treatment facilities found that the launch of the 988 Suicide and Crisis Lifeline was associated with a significant increase in peer support services, a significant decrease in psychiatric walk-in services, and statistically significant, albeit small, decreases in mobile crisis response and suicide prevention services.

Meaning Mental health officials and policymakers should consider strategies to boost the financing and availability of crisis services at mental health treatment facilities to meet increased demand generated by the 988 Suicide and Crisis Lifeline.

Abstract

Importance The launch of the 988 Suicide and Crisis Lifeline (988) in July 2022 aimed to enhance access to crisis mental health services by replacing the National Suicide Prevention Lifeline with a more memo-

rable number and expanding the Lifeline scope beyond suicide. However, 988's success relies on the availability of community crisis services.

Objective To examine whether the launch of 988 was associated with the availability of crisis services.

Design, Setting, and Participants This cohort study characterized trends in crisis services offered by US mental health treatment facilities (MHTFs) from November 1, 2021, through June 30, 2023. Longitudinal data were from the Mental Health and Addiction Treatment Tracking Repository, which contains daily instances from the Substance Abuse and Mental Health Services Administration's Behavioral Health Treatment Locator. The analysis includes licensed MHTFs that completed the National Substance Use and Mental Health Services Survey. Proportions of facilities offering 4 specific crisis services were calculated nationally and at the state level. Mixed-effects logistic regression was used to assess changes in availability of each crisis service after the launch of 988, controlling for MHTF characteristics.

Exposure Launch of 988 in July 2022.

Main Outcomes and Measures Outcomes were the availability of mobile crisis response services, psychiatric emergency walk-in services, suicide prevention services, or peer support services.

Results Across 15 623 MHTFs (184 769 observations; 79 268 before and 105 501 after the 988 launch), the largest changes were observed for availability of peer support services, which increased from 39% (n = 31 170) before to 42% (n = 44 630) after the 988 launch ($P < .001$), and emergency psychiatric walk-in services, which decreased from 32% (n = 25 684) before to 29% (n = 30 300) after the 988 launch ($P < .001$). When controlling for MHTF characteristics, after the 988 launch, the odds of peer support availability increased 1.3% per month (odds ratio, 1.013; 95% CI, 1.009-1.018), and the odds of emergency psychiatric walk-in service availability decreased by 0.6% per month (odds ratio, 0.994; 95% CI, 0.989-0.999). Availability of other service types also decreased at the national level, with mobile crisis response decreasing from 22% (n = 17 071) before to 21% (n = 22 023) after the 988 launch and suicide prevention decreasing from 69% (n = 54 933) before to 68% (n = 71 905) after the 988 launch. Significant variation across states was observed in service availability trends before and after the 988 launch.

Conclusions and Relevance This study found that the launch of 988 did not coincide with significant and equitable growth in the availability of most crisis services except for a small increase in peer support services. These findings suggest that strategies are needed to boost the financing and availability of crisis services to reduce disparities and increase 988's likelihood of success.

HEALTH

Since 988 launch, mental health crisis services have faltered

Study shows the nationwide system is falling well short of its potential, while funding issues loom

Adobe

By Theresa Gaffney Jan. 29, 2025

Morning Rounds Writer and Podcast Producer

In July 2022, 988 launched as the number anyone across the country could dial in a mental health crisis. It's one entryway to a sprawling system of mental health care options, but new research shows that since then, critical crisis services have not become more

available — a key objective of the nationwide rollout, designed to strengthen an underfunded, patchwork system that left many people alone in times of crisis.

While calls to the national hotline have continued to increase, fewer psychiatric facilities are offering emergency psychiatric walk-in services, mobile crisis response units, and suicide prevention services, according to a study published Wednesday in JAMA Psychiatry.

"988 isn't going to reach its full potential until there's a full system of crisis services in every single community," said Hannah Wesolowski, chief advocacy officer at the National Alliance on Mental Illness.

The downward trends didn't surprise experts, who said that funding for crisis care services has long been an issue. But as the Trump administration throws all types of federal funding into question, some worry that publicly funded facilities will only face more problems.

"The federal freeze in funding is really troubling and disturbing," said Ashwini Nadkarni, the associate medical director of psychiatry at Brigham and Women's Hospital in Boston. "It's a situation of great complexity, ambiguity, volatility and uncertainty."

Researchers at RAND followed changes in crisis services offered by psychiatric facilities, using Substance Abuse and Mental Health Services Administration data from between November 2021 and June 2023. Out of more than 15,600 facilities, the proportion offering emergency psychiatric walk-in services dropped from 32% to 29% during that period. That was the largest decrease among the tracked services, though the researchers found significant variation in availability from state to state both before and after 988 launched.

By June 2023, only 21% of facilities had mobile crisis units, and 68% offered suicide prevention services. Just one service was more available over time to people seeking help: peer support services, which jumped from being available at 39% of facilities to 42%.

It's important to note that the RAND study focused on psychiatric facilities, meaning that services offered at medical emergency departments, schools, in community health centers, or other doctor's offices aren't included, Polina Krass, a pediatrician and researcher at

Center for Violence Prevention, wrote in an email. The data are also self-reported from those facilities.

Publicly funded facilities and those that accepted Medicaid or private insurance were all more likely to offer crisis services compared with their counterparts. In particular, certified community behavioral health clinics (CCBHCs), which receive Medicaid funding and federal grants, are required to provide crisis services. There are only around 500 CCBHCs across the country, but study author and RAND policy researcher Jonathan Cantor saw them as a "bright spot" that could serve as a model for other types of providers in the future.

It's still unclear how the federal freeze on funding could affect these providers. While 988 launched in 2022 under former President Joe Biden, it was Donald Trump, in the fall of 2020, who signed it into law.

There was an influx of federal funding for mental health crisis services when the number launched, but the law also gave states the ability to charge fees on wireless service as one sustainable funding method. Typically this looks like a charge of 75 cents or less per line per month that gets passed on to wireless customers throughout the state. Ten states have put such fees in place.

"Something we've been telling states is: You can't rely on federal funding forever," Wesolowski said.

The study authors weren't able to investigate the causes behind changes in service availability. More "fine-grain data" are needed on county-level offerings, Cantor said. He'd also like to work on linking state-level policies to trends in crisis service offerings, to see which particular services might be making a difference.

And while SAMHSA posts overall performance metrics for 988, specific call log data on what people are calling about, where they are calling from, and the referral outcomes are not publicly available. "Having more transparency around 988 data may help us build a more useful and equitable crisis service," Krass wrote.

988 counselors answered more than 5,700,000 calls in 2024. That's 89% of all the calls they received — a lower percentage than the 91% they answered in 2023.

"If we don't actually enhance access to care," Nadkarni said. "Then one wonders how much we're actually achieving."

If you or someone you know may be considering suicide, contact the 988 Suicide & Crisis Lifeline: call or text 988 or chat 988lifeline.org. For TTY users: Use your preferred relay service or dial 711 then 988.

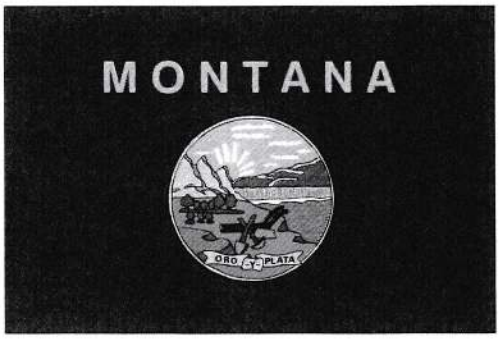
Commentary | Article | January 30, 2025

Montana's Mental Health Crisis: How One County's Mobile Crisis Response Team Is Filling Gaps and Saving Lives

Author(s): Ryan Mattson

Listen 0:00 / 10:14

How are organizations in Montana working to help better mental health care accessible across the state?



Speedfighter/AdobeStock

Montana's breathtaking mountains, expansive landscapes, and stunning skies create a paradise for many. Yet, beneath this beautiful exterior lies a troubling reality: the state ranks 50th out of 51 in adult mental health care.[1] With 1 of the highest rates of mental illness and the lowest access to mental health services, many residents struggle to find the support they need.

The sheer geographic distance between health care providers, coupled with a lack of infrastructure, has resulted in individuals in a behavioral health crisis being taken to county jails or emergency departments (ED)—both of which are ill equipped to handle the behavioral health and substance use issues that are presented in these heartbreaking and complex situations. Should someone need access to specialized inpatient care, they must seek care at 1 of the 2 closest behavioral health hospitals to Gallatin County—which are located nearly 240 miles apart. The lack of a true 72-hour involuntary hold process and the crumbling state hospital further compound the problem, resulting in individuals being released back into the community without appropriate treatment or follow up. To try and avoid jail or the ED, law enforcement officers are left to try and fill in as makeshift social workers and counselors for those experiencing behavioral health emergencies, rather than focusing on public safety issues.

Gallatin County, like much of Montana, reflects the broader statewide concern. Recognizing the need for change, Gallatin County completely overhauled 1 aspect of its behavioral health crisis response system. Initially launched in 2019, the Co-Responder Program provided immediate access to behavioral health care to those in the community, sending a mental health provider to work alongside first responders. However, it had limited response options and fell short of its intended purposes.

Connections Health Solutions was brought in during 2022 to lead the program's turnaround, evolving it into what is now known as the Gallatin County mobile crisis response team. Since taking over the program, Connections has delivered

impressive results, including faster response times, reduced law enforcement time at behavioral health calls, and better outcomes for individuals in crisis.

The mobile crisis response team now serves as a model for other rural communities seeking to enhance a critical component of its crisis response system. Critical to the program's success was the team's focus on 4 key areas:

- Proper identification of mental health calls
- Building trusted partnerships to increase effectiveness and efficiency
- Developing creative solutions that increase access to care
- Leveraging data to improve performance

Proper Identification of Mental Health Calls

Developing a method to identify mental health calls within the law enforcement system was crucial to addressing the specific needs of the community. Gallatin County dispatchers manage approximately 14,000 emergency calls each month, and accurately identifying mental health calls would be vital for the mobile team to effectively resource plan.

To start the process, law enforcement diligently worked with 911 and other community partners to run 3 reports with information from the Computer Assisted Dispatch (CAD). The data collected was then used to identify:

- Calls marked as mental health related
- The number of involuntary holds
- Calls where the mobile crisis team had been previously dispatched

They then used specific keyword searches to uncover any remaining calls that were not identified via the reports. The analysis allowed the team to create heat maps (**Figure 1**) that indicated where most calls originated and detailed areas with higher demand for mental health services. These insights could then be used to launch targeted, more efficient responses.

Building Trusted Partnerships to Increase Effectiveness and Efficiency

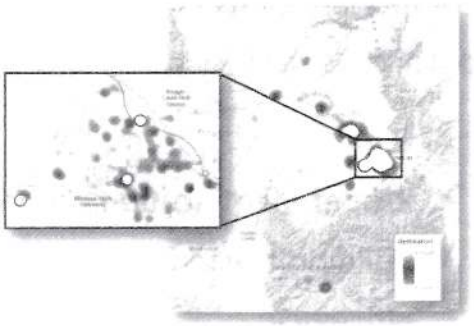


Figure 1. *Adapted from JG Research*

Recognizing that no single agency can address the behavioral health crisis alone, the team invested time in strengthening relationships with key stakeholders like law enforcement, emergency services, Help Center, Inc, and Montana State University to improve the program's efficiency and effectiveness within the community.

After successfully working together to identify mental health calls, law enforcement gave the mobile crisis response team access to the CAD system, which enabled the team to proactively stage themselves near locations where 911 had been called and first responders dispatched. With this access, they can notify dispatch and law enforcement of their availability. Once law enforcement clears the scene, the mobile team can quickly step in, conduct evaluations, and perform interventions. The team's real-time monitoring and proactive staging have established a least intrusive response in the community, which has helped to decrease the chance of protective custody and the need for higher levels of care. Now,

more than 90% of the time, the team is enroute before requested and has maintained a less than 11.9-minute response time.

"Since its inception, the Gallatin Mobile Crisis Response Team has positively impacted law enforcement in our community. First, it has reduced the amount of time law enforcement spends on mental health calls. Second, it lessens the need for law enforcement to keep up with the ever-changing mental health resources in our community. The team is well-informed on all our mental health partners. They can connect people in crisis to the correct resource directly. Lastly, the GMC has been a great partner to work with. They bring a positive attitude and are a joy to work with," saidErin Taylor, Gallatin County Sheriff's Office.

Furthermore, an enhanced partnership with Help Center, Inc, which operates the 988 hotline, enables the mobile crisis team to be dispatched directly, allowing for a civilian-first response and removing the need for law enforcement to respond when safe and appropriate.

Developing Creative Solutions to Increase Access to Care

In the absence of a dedicated crisis response center, the mobile crisis response team has developed innovative ways to provide critical support to those in need. Recognizing that jails are ill equipped to provide psychiatric services, the team partnered with local correctional facilities to offer mental health evaluations. They also work closely with the local health system's psychiatric emergency services (PES) unit, whose purpose is to address acute crises, meet individuals wherever they are prior to a potential admission to the PES, and work with them to facilitate a warm hand off to the appropriate level

of treatment, whether that be at another treatment center or a connection to a community resource.

One of the most impactful partnerships the team has forged is with Human Resource Development Council's Warming Shelter. By offering services within the shelter, the mobile crisis response team has been able to reach a particularly vulnerable population in a setting where they feel safe. This proactive approach eliminates the need for law enforcement involvement, which can often exacerbate the situation. By providing these services, even if they may not be counted as a "mobile response," the team is helping to increase access to life-saving care and fill critical gaps in the county's crisis response system.

Leveraging Data to Improve Performance

Over the past 2 years since relaunching as the mobile crisis response team, there has been an abundance of data to review and analyze. The team constantly and consistently reviews call volumes, average time to arrive on scene, average time spent on scene, community disposition rates, referrals, and other key performance indicators to determine opportunities to improve efficiency and effectiveness. Using the data, the team has been able to identify service gaps, especially in more remote regions, and allocate resources more strategically. This data-driven approach has led to the team making program improvements, resulting in a 77% average reduction in law enforcement time spent on mental health calls, allowing law enforcement to spend more time on public safety issues. It has also helped them to continue to decrease their average response time to 11.9 minutes after finding better ways to integrate into response systems and stage appropriately. Lastly, data has

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helped the team deliver better interventions in the field, which is demonstrated by their 86% success rate of keeping individuals in the community, diverting them away from jails or EDs.

In the spirit of partnership and transparency, the team also shares the data with key stakeholders. The team reports out monthly, sharing key data insights and discussing trends to uncover areas for continuous improvement. These regular reviews allow the team to adjust their strategies in real time, fostering stronger collaboration and ensuring their efforts align with evolving community needs.

Continuing to Move Montana Forward

There is still much work to be done. Additional funding is needed to secure the program's long term sustainability, and the team works closely with elected officials to help make legislative change in reimbursement. The team continues to build partnerships, particularly with rural communities that are still underserved, and expand the reach of mobile crisis teams. By focusing on partnerships, creative solutions, and data driven management, the team has created a system that not only responds more effectively to crises but also prevents them from escalating. These efforts have reduced the burden on law enforcement, improved outcomes for individuals in crisis, and strengthened the overall behavioral health infrastructure in Gallatin County.

Mr Mattson *is the director of social services for Connections Montana, where he has led the mobile crisis response team since December 2022. Ryan is a Licensed Clinical Professional Counselor and a Certified Mental Health Professional Person*

whose career has been driven by his passion for helping those experiencing a behavioral health crisis. Prior to joining Connections, Ryan worked as the Crisis Intervention Specialist (CIS) Supervisor at Bozeman Health and the Service Line Director of Crisis at Western Montana Mental Health Center.

Reference

1. Mental Health America. Mental health america adult data 2024. Accessed January 21, 2025. https://mhanational.org/issues/2024/mental-health-america-adult-data

Related Content

February 5th 2025

Wilsa M. S. Charles Malveaux, MD, MA, FAPA, Named Psychiatric Times Sports Psychiatry Section Editor

Wilsa M.S. Charles Malveaux, MD, MA

Community Behavioral Health Care Professional Loan Repayment Program

The number of awards made through this program, as well as the individual dollar amount awarded, are subject to sufficient annual appropriations by the Illinois General Assembly and the Governor.

You may either scroll through this page, or click on any of the following links to go directly to a specific topic:

The Community Behavioral Health Care Professional Loan Repayment Program provides loan repayment assistance to qualified mental health and substance use professionals. The program was designed as incentive for recruitment and retention of those who practice in underserved or rural areas. It seeks to help address the shortage of Illinois community-based behavioral workers that causes disparities in access to critical mental health and substance use services. The amount of the annual award to qualified applicants to repay their student loan debt is based on their position and may be received for up to four years.

Eligibility

To be eligible, you must:

- be a U.S. citizen or an eligible non-citizen
- be an Illinois resident
- have an outstanding balance due on an eligible educational loan (includes Stafford loans, Graduate PLUS loans, consolidation loans, Supplemental Loans for Students, alternative loans and other types of government and institutional loans used for education expenses)
- be a qualifying behavioral health professional who meets licensing requirements of the Illinois Department of Financial and Professional Regulation, holds certification as a Certified Alcohol and Drug Counselor from the Illinois Alcoholism and Other Drug Abuse Professional Certification Association or has attained the required educational credentials:
    - psychiatrist
    - advanced practice registered nurse (APRN)

    - physician's assistant
    - **psychologist (PsyD, PhD)**
    - licensed clinical social worker (LCSW)
    - **licensed clinical professional counselor (LCPC)**
    - licensed marriage and family therapst (LMFT)
    - **certified alcohol and drug counselor (CADC)**
    - certified recovery support specialist (CRSS)
    - Professional possessing a Master's degree in counseling, psychology, social work, or marriage and family therapy
    - Professional possessing a Bachelor's degree in counseling, psychology, or social work
- have worked for at least 12 consecutive months* immediately prior to applying for this program in a community mental health center, behavioral health clinic, substance use treatment center, or State-operated psychiatric hospital licensed or certified by the Department of Human Services or the Department of Healthcare and Family Services in an underserved or rural Illinois health professional shortage area (HPSA) mental health discipline
- be currently employed in a professional community healthcare center (as listed above) at the time of application and remain so employed for a continued 12 month period* for each year assistance is applied for and received, and
- not be in default on any federal guaranteed educational loan nor owe a refund on a grant or scholarship program administered by ISAC.

*Periods of vacation and leave of absence provided by your employer count as time worked when calculating the required employment timeframes.

How to Apply

The 2024-25 Community Behavioral Health Care Professional Loan Repayment Program application may be accessed via the Program Applications & Status Checks area of the Student Portal. The online application has built-in edits to prevent errors, and we will send immediate confirmation to your e-mail address that your application has been received. If your application, including required documentation, is incomplete, you will receive a letter from ISAC explaining the reason(s) and advising how to resolve the issue. Each year you wish to apply for this program, you must submit an application. Qualified applicants will be sent a Notice of Eligibility letter from ISAC.

In order to be considered timely, the Community Behavioral Health Care Professional Loan Repayment Program application for the 2024-25 academic year (i.e., 2025 Award Year) must be submitted on or before May 31, 2025, which is the priority consideration date.

Untimely applications (i.e., those received after the priority consideration date) are considered for as long as funding remains available after all timely, qualified applicants have been awarded.

Changes to Application Data

If, after submission, you need to change your response(s) to any item(s) and/or update any information after the application has been submitted, you will need to provide the information to ISAC. Examples of items that may need to be updated include demographic information (i.e., name, address, telephone number, etc.), and/or information about your outstanding loans and the loan holder/servicer. These changes can be submitted to ISAC using one of the below methods, but cannot be done over the telephone.

- via e-mail to isac.studentservices@illinois.gov
- via FAX to 847.831.8549
- via letter to ISAC, Program Operations, 1755 Lake Cook Road, Deerfield, IL 60015-5209

The request must include the last four digits of your Social Security number (for identification purposes) and clearly state what change(s) need to be made. These changes will not affect the application "received date."

Required Documentation

It is recommended that you gather and organize the documents needed to complete your application before starting to fill out the interactive form. The online process includes the option of uploading and submitting required documentation. Acceptable uploaded files must have one of these file extensions: .pdf, .jpg, .jpeg, .doc, .docx.

If you are unable or prefer not to submit your documentation electronically, you may instead mail it via U.S. mail to ISAC Dept. D, 1755 Lake Cook Road, Deerfield, IL 60015-5209.

You must submit a current loan account statement that includes your full first and last names and address (dated within 30 days of the date of the application) from your loan holder/servicer showing outstanding balances for each eligible educational loan. The statement(s) must include:

- the name of the loan holder/servicer
- the payment address of the holder/servicer
- area code/phone number of holder/servicer
- account number
- type of loan (Federal Direct, Stafford, etc.)
- monthly payment amount
- outstanding balance

How Funds Are Awarded and Disbursed

Recipients are selected from among qualified new and renewal applicants. The total number of awards each year is contingent on available funding. If funding in any given year is insufficient to pay all eligible applicants, awards will be determined in the following order:

- renewal applicants, in the order in which their applications were received
- new applicants, using the mental health portion of the HPSA database to rank eligible rural and underserved applications, giving priority to those in the areas with the highest degree of shortage (score) for that applicant's profession. If multiple applicants receive the same score, applications will be given consideration in the order in which they were received.
    - If an applicant works for an organization located in an HPSA mental health discipline that has satellite clinics and the applicant more than one of the clinics, the highest HPSA score where the applicant works will apply.
    - If an applicant works for different employers in multiple HPSA mental health disciplines having different degrees of shortage, the location having the highest HPSA mental health discipline score will apply.

Each fiscal year, no less than 30% of program funding will be reserved for awards to minority applicants of African American or Black, Hispanic or Latinx, Asian, or Native American origin. If enough applications are not received from qualified minorities on or before January 1 of a given fiscal year to award 30% of the funding to qualified minority applicants, then a portion of the reserved funds may be awarded to other qualified applicants.

The award amount is based on the applicant's remaining balance on eligible education loans, not to exceed:

- $40,000 per year for a psychiatrist
- $20,000 per year for an advanced practice registered nurse or a physician assistant
- $20,000 per year for a psychologist who holds a doctoral degree
- $15,000 per year for a licensed clinical social worker, a licensed clinical professional counselor or a licensed marriage and family therapist
- $12,000 per year for a professional possessing a master's degree in counseling, psychology, social work, or marriage and family therapy
- $6,000 per year for a professional possessing a bachelor's degree in counseling, psychology, or social work
- $4,000 per year for certified alcohol and drug counselor, or a certified recovery support specialist.

There is a minimum of – 10 weeks turnaround from the date approved recipients are notified by ISAC to when funds are disbursed. Depending on the volume of payment

vouchers being processed by the State of Illinois Comptroller's Office, this timeframe may increase. Proceeds will be remitted directly to the holder of the loan(s) to be repaid.
Before an award can be made or funds can be disbursed, ISAC must receive certification of each applicant's employment for the required time period. Certification is provided directly to ISAC by qualifying community mental health facilities.

Processing Updates

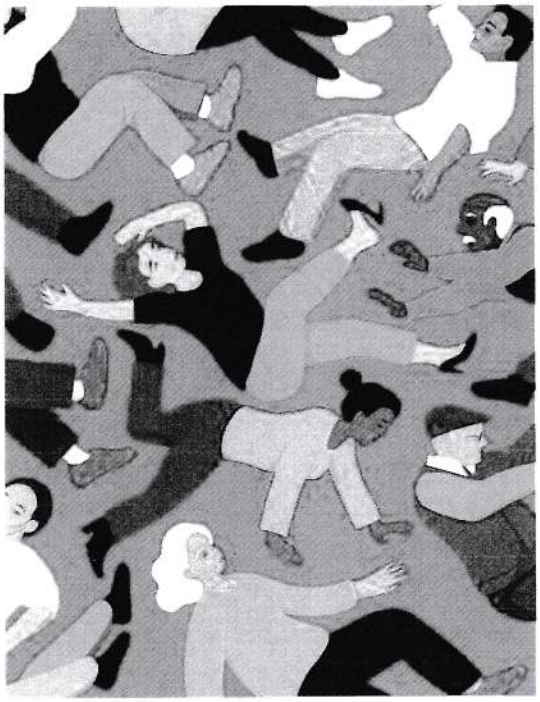
Note that ISAC routinely updates this section as new information becomes available. Be sure to check back periodically for the current processing status.

For the 2025 Award Year

(Last updated on October 24, 2024)

ISAC is accepting Community Behavioral Health Care Professional Loan Repayment Program applications for the 2025 Award Year (July 1, 2024 – June 30, 2025).
In order to be considered timely, the application for 2024-25 **must be submitted on or before May 31, 2025**, which is the priority consideration date.

Click here to access the Community Behavioral Health Care Professional Loan Repayment Program application.



Why Does America's Falling Epidemic Keep Getting Worse?

The risk of a dangerous fall is rising for Americans over 65. Distraction, lack of physical activity and ill-fitting shoes can all be part of the problem.

By Peter Funt

More than 1 in 4 people over age 65 fall each year. Earlier this month, the veteran TV host and comedian Jay Leno was one of them. Leno, 74, left his hotel near Pittsburgh looking for a bite to eat. It would have been a long walk to the restaurant, so he took a shortcut down a grassy hill. A tumble on the slope left him with a broken wrist and significant bruises to his face and entire left side.

Leno still managed to do his comedy act that night. He was luckier than many fall victims. Every year, falls among older Americans result in about 3.6 million emergency room visits and 1.2 million hospital stays, at a cost of roughly $80 billion. Nationwide, 41,000 senior citizens die from falls annually, according to the Centers for Disease Control and Prevention. In recent years, prominent figures such as comedian Bob Saget, former Connecticut Sen. Joe Lieberman and Ivana Trump died after a fall.

And despite progress in care and prevention techniques, a University of Michigan study found that the number of falls goes up about 1.5% every year. "It could be that efforts aren't working—or that they are, by mitigating even worse potential injury risk in the population," said Geoffrey Hoffman, a gerontologist at the University of Michigan. "Either way, more investment in prevention and funding for fall education and prevention programs would help."

The CDC operates a program known as STEADI (Stopping Elderly Accidents, Deaths and Injuries) to assist healthcare providers in screening older patients for fall risk factors, such as a history of falls, vision problems, inadequate Vitamin D intake and foot problems. In one common test, the patient must get up from a chair, walk 10 feet, turn around, walk back and sit down. If this takes more than 12 seconds, they are deemed to be at risk for a fall.

Earlier this year, Rep. Carol Miller of West Virginia, a Republican, introduced legislation to make fall-risk assessment part of Medicare's annual wellness benefit for all seniors. The bill, known as the SAFE Act, would also direct the Department of Health and Human Services to report annual statistics about falls to Congress.

"I'm a senior myself," Miller told me soon after her 74th birthday. "You fall, you hurt yourself, you go to the hospital. I had a neighbor who recently fell on a ladder in the kitchen and hit their head and their hip, and they're still in the hospital. It's a tough thing. Americans are aging!"

CDC data show a wide disparity among states in terms of frequency of falls. In Alaska over 38% of seniors suffer falls each year, with South Dakota next at 34%. When it comes to the risk of death from falling, Wisconsin has the highest rate, with 176 fatalities annually per 100,000 residents over age 65. Minnesota and South Dakota are next, at 140. Illinois has the lowest incidence of falls at 20%, followed by Connecticut and Hawaii at 21%.

Jennifer Vincenzo, a professor of physical therapy at the University of Arkansas who studies falls among older Americans, notes that "the states with the lowest level of physical activity have the worst rates of falls. If people are doing more activity, they potentially will be at a lower risk."

Nationally, the death rate from falls jumped 41% from 2012 to 2022, the latest period for which statistics are available. Among seniors, the contributing factors for falls are frustratingly complex. Reaction to prescription drugs, impaired vision and even such basic things as loneliness or ill-fitting shoes often add to the risk of falling.

"There has also been research on dual tasks, like doing more than one thing at a time," Vincenzo notes. "It's hard for you to focus on movement if you're focusing on doing another task, talking on the phone or texting, so that if you have impaired balance or walking problems, you're not going to pay attention to that and potentially fall."

The National Council on Aging advises older Americans to take a free online risk survey. Seniors should also review medications with regard to possible impact on stability, acquire a medical alert device if affordable, and create a home safety checklist, which can include getting rid of small throw rugs, adding a bathroom night-light, avoiding shelves that are too high to reach safely and installing grab bars.

Vincenzo's studies indicate that only half of older adults follow recommendations after getting a fall-prevention screening. Predictably, she found that those who didn't suffered higher rates of falls.

Many falls among older Americans go unreported, but documented incidents total about 14 million a year. One case involved a 75-year-old woman in Salinas, Calif., who fell in her bedroom last June and remained on the floor, unable to stand, until her son arrived for a visit some 16 hours later. Following a lengthy hospital stay, her family got her a monitoring device from the medical alert company Lifeline, one of several firms in what has become a $4 billion industry.

> 'It's hard for you to focus on movement if you're talking on the phone or texting.'
>
> JENNIFER VINCENZO
> Physical therapy professor

On Nov. 8, the woman fell again, leaving her with a severely fractured arm. This time the device she was wearing around her neck sensed the fall and automatically triggered a message to a dispatcher via telephone landline. Within seconds, the dispatcher's voice came through a speaker, addressing the woman by her first name. A fire department rescue unit was contacted and responders were able to enter the house using a key in a lockbox, supplied as part of Lifeline's $48 monthly service.

"It's been literally a life saver," said the woman, who lives alone following her husband's death. Lifeline has now introduced a "totally wireless" option that allows users to use the fall detection system anywhere in the U.S. The market for standalone, mobile and landline medical alert systems is expected to increase to $4.6 billion next year, reflecting annual growth of more than 12%.

Turning to a bit of self-deprecating wit following his recent fall, Jay Leno quipped, "The great thing about this age is you don't learn from your mistakes, you just keep doing the same stupid thing." That's exactly what healthcare experts hope to change through education, testing and behavior modification. As Vincenzo warns, "The highest risk factor for having a fall is having had a fall."

Peter Funt is a journalist and TV host and the author, most recently, of "Playing POTUS: The Power of America's 'Acting Presidents.'"

ABOUT FACE

I Finally Learned It's Not So Hard to Throw a Ball

Growing up, I loved reading and drawing and hated playing catch. In my late 20s, I learned I could surprise myself.

By Shaan Sachdev

WHEN I WAS 5 years old, my father asked me to play catch for the first and last time. After shielding my face from the oncoming ball, I burst into tears and demanded we do something else.

"Sure," he said gently. "Shall we play music or make a puzzle?"

I'll never forget his forbearance. A gifted athlete himself, he coached Little League softball and soccer, and yet he felt no need to drill his son in the hardy arts of throwing and catching objects. He didn't once push me to try out for either team.

My lifelong sfaireshobia (which apparently is the correct term for a fear of airborne spheres) accompanied my fear of all things ostentatiously masculine, whether building toy helicopters, wearing backward hats or peeing in side-by-side urinals. I even found the greeting "Hey, man" to be intimidating.

The truth is, I was given to delicate, wholly unrowdy activities. I loved reading, drawing and playing musical instruments. I reveled in the intangible, especially words. I'd spend my recesses indoors, talking to teachers.

But despite my father's cool, I couldn't avoid balls. It got worse in high school, when boys could throw farther and farther and gym class grew proportionally terrifying. I'd slip to the back of the kickball line, one student at a time, until the teacher would notice and blow his whistle, forcing me to exhibit my feeble, discoordinated kicks for a snickering crowd of adolescents.

Upon graduating high school, I vowed to never again throw, catch, kick or even touch one of those dreaded circular playthings cherished by men the world over. At this, I succeeded. Well into my 20s, I exercised at gyms or went running daily, but I almost never came into contact with a ball.

Then a pandemic swept the world, and gyms shut their doors. I found myself doing calisthenic routines at playgrounds and parks. And there, for the first time in a decade, I also found myself in dangerously close proximity to throwers and catchers.

Suddenly, balls of all stripes were rolling in my direction. Baseballs, tennis balls, basketballs, volley balls, soccer balls. Each stray advance was accompanied by a look of expectation: "Hey, man, mind tossing it back?" I'd pretend to neither see the ball nor notice its owner's dawning irritation. But I knew how it looked, and I felt as if I were back in high school.

Yet, by my late 20s, I'd learned that I could surprise myself, that I was more powerful and resourceful than long-lodged self-conceptions might permit. One drizzly afternoon at a playground in Manhattan, a basketball whirled toward me as I was mid-pull-up. A kid about age 10 glanced my way. He had no idea that he loomed as large as an NBA player in my imagination. I knew by then that I had three seconds to act.

I let go of the bars and walked over to the sinister orange orb. I picked it up. It felt lighter than I'd remembered. I rolled it back. Not quite hard enough—the kid had to walk a few steps to get it—but he nodded appreciatively at me, and I felt a rush of affiliation. Maybe this wasn't so hard after all!

On that day, I made a small but weighty pledge of self-reformation: From then on, I would roll back the balls. Soon I was dribbling, even throwing them. And even when I failed to send one on an efficient or accurate course, I was met only with those gloriously fraternal nods of approval.

Had the world changed? Had I? Either way, I felt like I'd earned re-entry into the gruff cabal whose code word had eluded me since I could walk. Maybe I'd never known it.

This summer, while visiting my sister at her farm in Virginia, I picked up a stick and threw it as far as I could.

"Since when do you throw?" she asked as we watched her dog run after it.

I shrugged and didn't answer. Just one of the boys.

Shaan Sachdev is and essayist and cultural critic based in New York.

"About Face" is a column about how someone changed their mind.